



STATE OF MICHIGAN

DEPARTMENT OF HEALTH AND HUMAN SERVICES
LANSING

RICK SNYDER
GOVERNOR

NICK LYON
DIRECTOR

August 24, 2018

Steven Laidacker
Lakeside
3921 Oakland Dr
Kalamazoo, MI 49008

RE: License #: CI390201235
Investigation #: **2018C0214024**
Lakeside

Dear Mr. Laidacker:

Attached is the Special Investigation Report for the above referenced facility. Due to the violations of applicable licensing rules, sections of the contract and Implementation Sustainability, and Exit Plan (ISEP) requirements, a written corrective action plan is required. It should be noted that violations of any licensing rules are also violations of the ISEP and your contract. The corrective action plan is due 15 days from the date of this letter and must include the following:

- How compliance with each citation will be achieved; this includes identifying behaviorally specific action steps.
 - Repeat violations must include an explanation of why the previous corrective action plan did not result in compliance.
- Individuals directly responsible for implementing the corrective action step for each licensing statute and rule, Contract item, DHHS policy or ISEP section citation; e.g. workers, supervisors, program managers, director, etc.
- Specific time frames for each citation as to when the correction will be implemented and completed.
- How continuing compliance will be maintained once compliance is achieved; this includes identifying specific action steps for continuous monitoring.
 - MiSACWIS users with access to the Book of Business, InfoView Reports and the Monthly Child Welfare Management Report should incorporate the use of these tools as well as other data management reports released by the Department for continuous monitoring.
- Signature of the responsible party and date.

If you desire technical assistance in addressing these issues, please feel free to contact me. In any event, the corrective action plan is due within 15 days. Failure to submit an acceptable corrective action plan will result in disciplinary action.

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available, and you need to speak to someone immediately, please contact Claudia Triestram, the area manager at (616) 552-3662.

Please note that violations of any licensing rules are also violations of the ISEP and your contract.

Sincerely,

A handwritten signature in blue ink, appearing to read 'Paul Fatato', with a long horizontal stroke extending to the right.

Paul Fatato, Licensing Consultant
MDHHS\Division of Child Welfare Licensing
322 E. Stockbridge Ave
Kalamazoo, MI 49001
(269) 251-2471

enclosure

**MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF CHILD WELFARE LICENSING
SPECIAL INVESTIGATION REPORT**

I. IDENTIFYING INFORMATION

License #:	CI390201235
Investigation #:	2018C0214024
Complaint Receipt Date:	06/26/2018
Investigation Initiation Date:	06/26/2018
Report Due Date:	08/25/2018
Licensee Name:	Lakeside
Licensee Address:	3921 Oakland Dr Kalamazoo, MI 49008
Licensee Telephone #:	Unknown
Administrator:	Donald Nitz, Designee
Licensee Designee:	Donald Nitz, Designee
Name of Facility:	Lakeside
Facility Address:	3921 Oakland Drive Kalamazoo, MI 49008
Facility Telephone #:	(269) 381-4760
Original Issuance Date:	04/01/1990
License Status:	REGULAR
Effective Date:	09/18/2017
Expiration Date:	09/17/2019
Capacity:	124
Program Type:	CHILD CARING INSTITUTION, PRIVATE

II. ALLEGATION(S)

	Violation Established?
A few weeks ago, Resident C was sick and couldn't keep food or water down for five days. She did not receive any medical attention because Lakeside thought she was faking it. On the 5th day, Lakeside took her to Bronson Hospital and she was admitted and dehydrated. Lakeside still did not believe Resident C was sick even after admission. (unsure of date-not taking medication-laid in bed unable to wake up-no energy could hear-they made her go outside anyway Staff 13 and Staff 14- they believed she was faking it-no medical help-Staff 2 insisted that they take her to the ER-staff took to ER 3-11 through 2 IV-Staff 13 kept calling asking if it was fake-hospital admitted her until next day-refused to allow her to call grandmother- Staff 13 & Staff 5- told not allowed to let her use staff phone to call)	No
On 6/17/18, Resident B hurt her foot, but no nurses saw her foot until 6/20/18. Resident B was found to have a foot fracture. Nurses were told about the injury when it happened, but they denied being told. Resident B was treated on 6/20/18. (2 Sundays ago, outside doing slip and slide activity-resident tripped and caught foot funny foot swelled up-nurse did look at it Staff 4 (Nurse)-nurse gave medication-resident asked nurse to look at it and unprofessional with resident-iced and gave pain medication-did not see doctor until Wednesday-nurse hope said she didn't know anything about it on Monday-Wednesday found foot to be fractured)	No
Girls are allowed to shave their legs once a week. On 6/24/18 Resident D attempted suicide with one of the razors in her room. On 6/24/18, Resident A cut herself with a razor in a suicide attempt. Resident A got the razor from the once a week leg shaving. Resident A is being bullied by staff, Staff 9, and another student, Resident I. Staff 9 picks on Resident A. No details about the bullying or picking on are known. Resident A cut herself due to this. (Resident D: not keeping sharp objects locked up-when coming on shift sharps laying out-staff keys in sharps drawer-not on shift when Resident D sitting in room 37/7-room search found nothing-later day Resident D cut face and wrist-reported to Staff 2 therapist)-staff told another staff about it-doesn't believe they do	Yes

room searches-Resident A has a razor claimed she has since December-staff are not doing room searches but claim that they are-Resident A told me that she is cutting herself because she is being bullied by staff (Staff 9) and student Resident I -2-3 weeks ago came out of room with blood on wrists and Resident I and Staff 9 laughed at her-no sure if she received medical care)	
Additional Findings	Yes

III. METHODOLOGY

06/26/2018	Special Investigation Intake 2018C0214024
06/26/2018	Special Investigation Initiated - Face to Face – Staff 10 and Staff 11
06/27/2018	Contact - Face to Face - interviews with Staff 1, Staff 2, Staff 10, Staff 11, Resident A, Resident B, Resident C, Resident D and Resident E,
06/28/2018	Contact - Face to Face - interviews with Staff 3, Staff 4, Staff 5, Staff 6, Staff 7, Staff 8, Staff 9, Staff 10, Staff 11, Staff 12, Staff 13, Resident F and Resident H,
07/17/2018	Contact - Face to Face - interviews with Resident I
08/01/2018	Inspection Completed-BCAL Sub. Compliance
08/02/2018	Exit interview onsite – Staff 10 and Staff 11

ALLEGATION:

A few weeks ago, Resident C was sick and couldn't keep food or water down for five days. She did not receive any medical attention because Lakeside thought she was faking it. On the 5th day, Lakeside took her to Bronson Hospital and she was admitted and dehydrated. Lakeside still did not believe Resident C was sick even after admission. (unsure of date-not taking medication-laid in bed unable to wake up-no energy could hear-they made her go outside anyway Staff 13 and Staff 14- they believed she was faking it-no medical help-Staff 2 insisted that they take her to the ER-

staff took to ER 3-11 through 2 IV-Staff 13 kept calling asking if it was fake-hospital admitted her until next day-refused to allow her to call grandmother- Staff 13 & Staff 5- told not allowed to let her use staff phone to call)

INVESTIGATION:

Meeting with Staff 10 and Staff 11 at the facility on June 26, 2018 to initiate the investigation. Both report not knowing of the allegations but being willing to have staff available when this writer returned to begin the interviews.

Meeting with Resident C at the facility on June 27, 2018. Resident C was asked about the allegations that she was not provided medical treatment for several days and staff believed she was “faking”. Resident C shared the following information, “I was sick for five to six days and I couldn’t keep my medication down. The nurses kept telling me that I would get over it. I had to have a crutch to help me walk because I couldn’t keep my balance and I couldn’t sit up in a chair.” Resident C was asked about staff’s response to her illness and she indicated that the staff would talk to the nurses every day and that the nurses told staff to have her continue eating and drinking. Resident C recalled that she, “talked to the nurse every day at the med cart”. She was asked which nurse she spoke to and she replied, “(Staff 4) and (Staff 8)”. Resident C continued with her recall of staff’s reactions, “Staff acted like they were more concerned than they were, and they made me participate in kickball when I was feeling really bad. I went negative that week when I couldn’t participate because I had no medicine all week. Staff even told me that I was a hypochondriac.” Resident C was asked if she remember the staff that said she was a hypochondriac and she replied, “Staff 13 said it to me and she no longer works on our dorm”. Resident C was asked how she was finally taken to the hospital and she reported, “The only reason I went to the emergency room is because my therapist asked me to drink water and I told her I couldn’t drink water”.

Meeting with Resident E at the facility on June 27, 2018. Resident E was asked about any knowledge she might have about the allegations involving Resident C. Resident E reports observing Resident C throwing up and that she couldn’t eat anything. She was unable to provide any further information about the allegations.

Meeting with Resident F at the facility on June 27, 2018. Resident F was asked about having any acknowledge of the allegations with Resident C and she gave the following report. “Staff sent me back to her room to get her up and Staff 13 denied that she was sick. Staff 13 said she was faking and I know she wasn’t really faking. I felt like they didn’t care because they didn’t check her out.” Resident F was asked about other staff saying Resident C was faking and she reported that Staff 13 was the only staff who said this and that she said it in front of others.

Meeting with Staff 1 at the facility on June 27, 2018. Staff 1 reports that he is employed as a Youth Counselor and has worked at the facility for the past two years. Staff 1 was asked about his knowledge of the allegation that Resident C was not provided medical

care for an illness for several days. Staff 1 reports that he was not working when it was first reported that Resident C was reported being ill. He stated, "I'm not sure who she told, and I don't know what she said. I know the nurses were monitoring her and I trust the nurses did their job." Staff 1 indicated that he was never present when the nursing staff were talking with Resident C but that he believes "the hospital found something". Staff 1 did recall that Resident C was "ill for several days before they took her to the hospital". Staff 1 was asked how he concluded that she was sick, and he reports, "she was walking around the dorm and attempted to participate in activities for several minutes before sitting down, saying she was not feeling well. I remember once that she came out of the bathroom and reported that she vomited." She also didn't approach situations with the energy that she normally has."

Meeting with Staff 2 at the facility on June 27, 2018. Staff 2 reports that she is the primary therapist for the girl's dorm at the facility. Staff 2 was asked about her knowledge of the allegation that Resident C was not being provided appropriate medical care over several days. She gave the following reply, "Resident C told me that she had been sick for a very long time and the length of time she reported kept changing. She said she had trouble eating and was throwing up." Staff 2 was asked what action she took once being informed of Resident C's report and she indicated talking to Staff 16 and Staff 5. Staff 2 indicated that Staff 5 told her that "Resident C is making herself throw up". Staff 2 reports that she spoke to a couple of the other residents to determine the true nature of Resident C's claim of sickness and was told by Resident C's roommate that she was "faking". Staff 2 indicated that on the day Resident C was taken to the hospital, she reported having difficulty walking. She also indicated a belief that Resident C was trying to get people to notice her because "something was off" on her self-reported illness. Staff 2 described this "something off" as Resident C would "laugh and joke and then say she couldn't even lift her arm". She also reported that Resident C drank some water and then "she said she was going to throw up". Staff 2 was asked what she did with this information and she reports talking to Staff 3 who informed her that they were going to send Resident C to the hospital. Staff 2 indicated not being aware of who made the decision to send Resident C to the hospital. Staff 2 was asked about the length of time before her intervention and she reported, "I didn't read the notes for the weekend because I am feeling very overwhelmed right now. If I would have read the notes I would have talked to the nurse and told her that Resident C needs to go to the hospital."

Meeting with Staff 3 at the facility on June 27, 2018. Staff 3 reports that he is employed as a Campus Coordinator at the facility and has worked there for the past eight years. Staff 3 was asked about his knowledge of the allegations with Resident C and he gave the following report. "I remember Staff 2 calling me about Resident C. This was the first I had heard about it. After talking with Staff 2 I went to the nurse to talk about Resident C." Staff 3 indicated that the nursing staff told him they knew about Resident C and that she had been sick. Staff 3 recalled, "I told them (nursing staff) that I was waiting on their approval to send Resident C to the hospital and they indicated she should go". Staff 3 was asked who the nursing staff that he spoke with was and he was unable to recall which nurse it was. Staff 3 was asked about the procedure when a resident is sick

enough to take to the hospital and he reports, “the nurse will contact me to get them off campus or just let me know the resident is sick”. Staff 3 indicated that he informed Staff 10 that he was taking Resident C to the hospital. Staff 3 was asked about the allegation that staff thought Resident C was “faking” and he indicated that this is the first he has heard of this allegation. He was quick to reply that “if staff thought a kid was faking it’s not their call, the nurses make the call”.

Meeting with Staff 4 at the facility on June 28, 2018. Staff 4 is employed as a nurse at the facility and worked at the facility for the past nine years. She was asked about her knowledge of the allegations involving Resident C. Staff 4 reported being familiar with the situation with Resident C. She gave the following report, “Resident C was complaining of vomiting and this was the symptoms of the bug going around campus a week before. We believed that she had gotten the bug because she said she was not eating. We offered her Pepto-Bismol and told her we would keep an eye on her. We also asked the staff to keep an eye on her and witness any vomiting. The staff were asked to let us know what her food intake was like. Staff told us that for the first couple of days, Resident C was reporting that she was not feeling well but that she was still eating.” Staff 4 continued, “We told her to limit her eating, so her stomach could rest. I was off work for a couple of days and when I came back the other nurses were discussing that if Resident C continues to not eat we would need to check her lithium levels because of her medication.” Staff 4 was asked about the allegations that staff were saying Resident C was faking and Staff 4 reported that “no one told me that they thought she was faking. I don’t doubt that she had a stomach virus, but I believed that she likely had the stomach bug that was going around.” Staff 4 did report that they don’t typically send a resident to the hospital for a cold. She also reported that the hospital did report Resident C was “dehydrated with a stomach virus”.

Meeting with Staff 5 at the facility on June 28, 2018. Staff 5 reports working at the facility as a Group Leader and that she has been employed at the facility for the past year. Staff 5 was asked about the allegations with Resident C and gave the following report. “I remember that Staff 17 took Resident C to the hospital”. Staff 5 indicated knowing that Resident C was sick and that she said, “something about her asthma”. Staff 5 reports, “every time she talked to me I would get a hold of the nurse and I would tell her to sit out of activities when she said she was ill”. Staff 5 indicated that she “never heard any staff say she was faking”. She also indicated believing that the illness started with Resident A’s asthma.

Meeting with Staff 6 at the facility on June 28, 2018. Staff 6 reports being employed as a Youth Counselor. Staff 6 was asked about the allegations with Resident C and she gave the following report. “I worked a day she was acting groggy and not eating food. I was told by other staff that she was normal until she laid down at lunch time and couldn’t hold her food down. I never saw her vomiting, but she did tell me she was.” Staff 6 indicated that she was off work for a couple of days and when she came back to work the “situation was handled because Resident C had already seen a nurse”. Staff 6 was asked about staff saying that she was faking, and she reports, “I heard peers say she was faking”.

Meeting with Staff 7 at the facility on June 28, 2018. Staff 7 reports working at the facility as a Youth Counselor for the past six months. Staff 7 was asked about her knowledge of the allegations surrounding Resident C. Staff 7 gave the following report. "I was working when she claimed to be sick. I did everything I could to help her." Staff 7 was asked about the allegations of staff saying Resident C was faking and she reported that she "needed to have proof to believe" Resident C. Staff 7 indicated that she did see Resident C "vomit" and appearing "sweaty and hot". Staff 7 was asked about needed proof and she indicated that "lots of kids use it to cop out of responsibilities, but I don't remember saying to her that she was faking. If she was faking I would keep that to myself." Staff 7 indicated that she told Resident C she would provide Pedialyte, but that Resident C refused.

Meeting with Staff 13 at the facility on June 28, 2018. Staff 13 reports that she is employed as a Shift Leader and has worked at the facility for the past two years. Staff 13 was asked about the allegations about staff telling Resident C that she was faking. Staff 13 reports, "Resident C was struggling to get up and walk and it was hard for her to keep food down. We contracted the nurses several times. She used crutches to help herself walk and were told that she should eat small amounts of food at a time. She was also told to drink limited water." Staff 13 was asked specifically about the faking comments, and she reported, "I never said or heard anyone tell her she was faking and everything we did was placed in the daily notes".

Meeting with Staff 8 at the facility on June 28, 2018. Staff 8 reports that she is employed as a Registered Nurse at the facility. Staff 8 was questioned about her understanding of the allegations involving Resident C. Staff 8 reports that a lot of the residents were sick at the end of April and the dorm Resident C was residing in didn't have any reported illnesses. She indicated a belief that the illnesses finally made its way to Resident C. Staff 8 recalled, "I encouraged her with normal treatment for the illness that was on campus and she kept saying that she was throwing up, but I don't believe anyone witnessed her throwing up. She didn't look sick and produced large tears which suggest that she is not dehydrated." Staff 8 was asked about the reasoning that resulted in Resident C being taken to the hospital and she indicated that Resident C is taking lithium and if she was throwing up her appropriate levels of the medication could be negatively affected. Staff 8 indicated that the normal medical procedure is to wait five days while monitoring Resident C's symptoms. Staff 8 ended by stating, "we sent her to the emergency room because of lithium levels and to make sure she was alright".

Meeting with Staff 9 at the facility on June 28, 2018. Staff 9 reports that she has been employed as a Youth Counselor at the facility for the past year. Staff 9 was asked about the allegations involving Resident C and she gave the following information. "Resident C heard the other girls say she was faking. We took her to the nurse and followed what the nurses told us to do." Staff 9 continued, "she went to the nurse and told the nurse she couldn't walk. It seems that the crutches were not working for her because she told me she still couldn't walk. I went to Staff 3 and told him the situation. He took her to the hospital."

Meeting with Resident I at the facility on July 17, 2018. Resident I was asked about the allegations around Resident C. Resident I gave the following report regarding the allegations. "Resident C started not participating and refused to do her chores or activities. We had to help her get up and she even stopped going to school because she said she doesn't feel good." Resident I continued, "I guess she went to the nurse and said she couldn't keep her medication down. We kept trying to help her get through the day, but she held us up when she would stay in her bedroom or in the bathroom." Resident I indicated that this continued for about a week. Resident I was asked about the allegation of Resident C faking and reported, "When she was refusing to get up and another staff that she liked walked into her room, she jumped up and acted happy to see the staff. This is when people started believing that she was not as sick as she claimed."

APPLICABLE RULE	
R 400.4142	Health services; policies and procedures.
	(1) An institution shall establish and follow written health service policies and procedures addressing all of the following: (a) Routine and emergency medical, and dental, and behavioral health care.
ANALYSIS:	Evidence discovered during this investigation through interviews does not support the allegations of a lack of medical care for Resident C. All evidence supported that appropriate action was taken by the direct care staff by notifying the nursing staff. The evidence also supports that the nursing staff took appropriate medical action to provide care until it was determined that Resident C should be seen at the hospital.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

On 6/17/18, Resident B hurt her foot, but no nurses saw her foot until 6/20/18. Resident B was found to have a foot fracture. Nurses were told about the injury when it happened, but they denied being told. Resident B was treated on 6/20/18. (2 Sundays ago, outside doing slip and slide activity-resident tripped and caught foot funny foot swelled up-nurse did look at it Staff 4 (Nurse)-nurse gave medication-resident asked nurse to look at it and unprofessional with resident-iced and gave pain medication-did not see doctor until Wednesday-nurse hope said she didn't know anything about it on Monday-Wednesday found foot to be fractured)

INVESTIGATION:

Meeting with Staff 10 and Staff 11 at the facility on June 26, 2018 to initiate the investigation. Both report not knowing of the allegations but being willing to have staff available when this writer returned to begin the interviews.

Meeting with Resident B at the facility on June 27, 2018. Resident B was asked about the incident that resulted in her foot injury and the treatment she received. Resident B recalled that on Sunday the residents were on a “slip and slid on a hill when she “rolled my foot”. She continued, “there were rocks under the tarp that I caught my foot on while I was sliding down. I couldn’t walk so the students carried me inside and staff got me ice. The staff told me they texted the nurse.” Resident B indicated that this injury occurred at 6:50 pm and she was seen by the nurse at the med cart at 7:30 pm. Resident B recalled, “I was sitting on the couch elevating my foot when I had the nurse look at my foot. She looked at my foot and gave me aspirin.” She was asked what other care was provided and reports that Staff 5 “got me crutches”. She also indicated that the nurse told her she would return “but never did”. Resident B reports that Staff 4 (nursing staff) looked at her foot on Monday at the “morning med cart and just wrapped it up”. “She also told me to keep it elevated and wrapped up”. Resident B was asked about the process leading up to her being taken to the hospital and gave the following information, “Tuesday night at the med cart, Staff 8 (nursing staff) said that I needed to go to the doctors, but the campus coordinator said that there were not enough staff to take me to the hospital at that time. Staff took me the next day. They gave me an X-ray at the hospital and put my foot into a boot.”

Meeting with Staff 4 at the facility on June 28, 2018. Staff 4 is part of the nursing department at the facility and was asked about her awareness of the allegations with Resident B. She gave the following report, “I observed her about forty-five minutes after the incident took place. She told me it happened around 6:45 pm and I saw her at the med cart around 7:30 pm to 7:40 pm. I was the first nurse to be informed of the injury and I informed the other nursing staff.” Staff 4 continued her report of the situation, “They had her on the couch and had ice on her foot. She complained of ankle pain and I observed issues with the top of her foot and ankle. I told her to stay off her foot and gave her 600 mg of ibuprofen. I also told her we would keep an eye on it for swelling. I told her that we would provide crutches which I gave to Staff 5 within the hour.” Staff 4 indicated observing Resident B the next morning at the med cart and “Resident B rated the pain a little less”. Staff 4 continued, “I asked about the swelling and she said it was still swollen. When I looked the swelling appeared to be about the same and I encouraged her to continue keeping her foot elevated. I made sure she had more ice.” Staff 4 indicated that she let staff know about the course of treatment before giving Resident B more ibuprofen. Staff 4 indicated that she was off work on Tuesday and

Wednesday and that upon her return, she met Resident B at the med cart. She also indicated that when seeing Resident B, Resident B was in a boot and told her the pain was much less. Staff 4 reports that she followed up with another nursing staff who informed her that Resident B was not improving so they took her to the hospital. Staff 4 reports that they provided the appropriate treatment.

Meeting with Staff 5 at the facility on June 28, 2018. Staff 5 was asked about her knowledge of the allegations concerning Resident B. She gave the following report, “I was on a transport when Resident B broke her foot. I heard that she was sliding near the garbage cans. I returned to the dorm around 7:00 pm and talked with Staff 4 about the situation. Staff 4 told me to have Resident B keep her foot elevated and use ice as much as possible. We gave her ibuprofen and I got crutches from the Atlas Center.” Staff 5 was asked about the course of treatment and she indicated that “staff follow the direction given by the nurse”. Staff 5 indicated that the nursing staff made the call not to take Resident B to the hospital immediately following the accident. Staff 5 also indicated that she didn’t work the next Monday or Tuesday. She reports that another staff took Resident B to the hospital on Wednesday.

Meeting with Staff 8 at the facility on June 28, 2018. Staff 8 is part of the nursing staff and gave the following report regarding the allegations concerning Resident B. “Treatment was ibuprofen, rest and crutches. We made the decision to send her to the hospital after two days while using conservative measures and finding there was no improvement. I believe we needed to have an X-ray to make sure there was no issue.” Staff 8 indicated a belief that there was no delay and that they did everything appropriately.

APPLICABLE RULE	
R 400.4142	Health services; policies and procedures.
	(1) An institution shall establish and follow written health service policies and procedures addressing all of the following: (a) Routine and emergency medical, and dental, and behavioral health care.

ANALYSIS:	Evidence uncovered through interviews during this investigation does not support the allegation that Resident B was not provided appropriate medical care for a foot injury. Evidence supports that the direct care staff did follow procedures and the nursing care followed the medical procedures appropriately. Evidence also indicates that more than one nursing staff was involved in the decision making on a referral to the hospital.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

Girls are allowed to shave their legs once a week. On 6/24/18 Resident D attempted suicide with one of the razors in her room. On 6/24/18, Resident A cut herself with a razor in a suicide attempt. Resident A got the razor from the once a week leg shaving. Resident A is being bullied by staff, Staff 9, and another student, Resident I. Staff 9 picks on Resident A. No details about the bullying or picking on are known. Resident A cut herself due to this. (Resident D: not keeping sharp objects locked up-when coming on shift sharps laying out-staff keys in sharps drawer-not on shift when Resident D sitting in room 37/7-room search found nothing-later day Resident D cut face and wrist-reported to Staff 2 therapist)-staff told another staff about it-doesn't believe they do room searches-Resident A has a razor claimed she has since December-staff are not doing room searches but claim that they are-Resident A told me that she is cutting herself because she is being bullied by staff (Staff 9) and student Resident I -2-3 weeks ago came out of room with blood on wrists and Resident I and Staff 9 laughed at her-no sure if she received medical care)

INVESTIGATION:

Meeting with Staff 10 and Staff 11 at the facility on June 26, 2018 to initiate the investigation. Both report not knowing of the allegations but being willing to have staff available when this writer returned to begin the interviews.

Meeting with Resident A at the facility on June 27, 2018. Resident A was asked about the allegations involving her using a razor to cut herself while in her room. Resident A was unable to recall the timeframe of this incident but did admit that she went to her room and started cutting herself. She shared a belief that this may have occurred sometime in May or June of this year. She reports, "I had two razors in my room and a pencil sharpener." She was asked how she obtained these items and she recalled, "I took them out of the staff kitchen area from the large gray cabinet back in December. At that time, we had staff who didn't lock the cabinet." She was asked about the location of staff during that time and she indicated that they were "in the other bay area". She was

then asked about the cabinet being locked now and indicated that “it’s not been unlocked since then”. Resident A continued with her recall of the cutting incident, “I had my door closed and staff were not paying attention. The green hall staff didn’t come down to check on me while I was in my room. When I walked out of my room, I showed Staff 9 and Resident I and they both laughed at me.” Resident A was asked about the medical care she received and reports that the nursing staff never saw it because she “kept a paper towel and pressure” on the wound. Resident A reports telling her therapist “when it was almost healed” and that the therapist then told Staff 14 (Program Director). Resident A was asked about the follow up from staff, and she reports that they conducted a room search and found the razors and pencil sharpener. She also reports that there were room searches conducted prior to the staff finding out about her cutting but these “room searches were not thorough”. She suggested that these items “were in plain sight, laying on top” of her clothes in the top drawer of her dresser and “in a cubby”.

Resident A was asked about the allegations of bullying on the dorm and gave the following description. “The campus has changed because you never used to get bullied or made fun of by staff. Now they look in our file and tell us we are worth nothing. I told my counselor and she said she was going to talk with her supervisor about this.” Resident A was asked about these changes and reported that the campus seemed to change sometime in February 2018. She also stated that “now we have girls threatening to fight or run a lot and I no longer feel safe here. “Staff 14 has been more grumpy and not paying attention to our concerns. He is not supervising the staff and he is like our father who does our home passes and transportation.” Resident A continued with her description of the bullying, “I was going through a phase and Staff 9 and Resident I were being disrespectful to me. I was also having home issues at this time. Staff 9 called me a whore and a bitch, and she even told me ‘to go fuck myself’. That same staff even told me to kill myself a few times and Resident I also told me to kill myself.” Resident A finished by stating that Staff 9 will “pass notes for boys and girls to each other and when she is on shift, she really is not on the dorm. She also visits with her relationship person who is Staff 19.”

Meeting with Resident B at the facility on June 27, 2018. Resident B was asked about the allegations of bullying on the dorm. She gave the following report. “I don’t think there is really bullying going on and I have not seen this. I also have not seen staff mistreat residents. I have seen staff get upset with us and Staff 9 favors Resident I over the rest of the residents.”

Meeting with Resident C at the facility on June 27, 2018. Resident C was asked about the allegations of bullying on the dorm. She reported the following, “there is not bullying here, the girls are just mean to each other all the time and sometimes the staff get grumpy”.

Meeting with Resident D at the facility on June 27, 2018. Resident D was asked about the allegations of her having a razor in her room and self-cutting. Resident D reports

when “someone yelled at me I got triggered and ran to my room. When I lived with my mom and she yelled at me I would go to my room and cut on me. I slammed the door to my room and Staff 9 came in and said, ‘what’s the sense of closing the fucking door’ and slammed the door on her way out. I took the pencil sharpener and started cutting myself.” Resident D continued her recall, “I took off out of the back door and walked to the front of Lakeside. Staff 9 and Staff 13 came running after me. I took off my jacket and showed them the marks and told them you don’t care until you see blood. I started cutting on myself again and running backwards. They caught me and took away the blade.” Resident D was asked about the care she was provided after the incident. She provided the following information, “They took me to see the nurse and she wrapped up my arm. Then I was in my room again and staff were spotting me.” Resident D described the “spotting” as “staff had a chair in front of the door and the chair was against the wall”. Resident D indicated that Staff 6 was sitting in the chair in such a way that she could not see Resident D. Resident D continued, “I cut my face while in my room and when Staff 2 saw the cuts she wanted to talk to me.” Resident D indicated that she was in her room for approximately thirty minutes before Staff 2 came to see her. Resident D was asked what occurred after talking to Staff 2 and she indicated that Staff 9 came into her room and sat for a while. Resident D reports that she received no medical care for the cuts on her face and that staff did not see the cuts on her other arm. Resident D also shared that she “didn’t want to be alive that day because Staff 5 talks about me a lot and it makes me scared”. Resident D was asked how she obtained the razors and she shared that her past roommate gave them to her. She also shared that she had five razors in her room that she gave to Staff 2 when Staff 2 came to her room that day.

Resident D was asked about the allegations of bullying on the dorm and she provided the following information. Resident D indicated that Staff 9 yelled at her and slammed her bedroom door during the incident when Resident D cut her arms. She also indicated that Staff 9 said “what’s the sense of closing the fucking door” during this incident. Resident D states that Staff 9 also, “won’t talk to me when I’m rated negative and will cursing at us, saying ‘fuck’ a lot. Resident D did state that “all staff curse and tell us not to do it”. Resident D reports that she is “scared” of Staff 9. Resident D reported that Staff 5 “talks about me a lot and it makes me scared”. She also reports that Staff 5 “puts everyone on blast which puts their business out there for everyone and this causes us to cry. She does this a lot.” Resident D indicated that Staff 7 picks on several of the residents and shares personal things about the residents. Resident D shared that most of the “staff are on the phone all day” and “Staff 5 showed the kids a fight on her phone that she filmed”. Resident D also shared, “Staff 5 also has video chat and she let some of the girls talk to someone that the girls knew. Staff 9 let a girl use Facebook on her iPhone.”

Meeting with Resident E at the facility on June 27, 2018. Resident E was asked about her awareness of allegation of bullying on the dorm. She reports that no staff treat her differently but did share that Resident I “likes to put herself above the rest of the residents”. Resident E shared that Staff 16 is often “mean and disrespectful” to the residents and will “yell at the residents”. Resident E was asked about staff allowing

residents to use phones and she reports, “staff don’t let kids use phones. Staff have phones in their back pockets for emergencies.” Resident E was also asked about staff passing notes and she indicated that “staff do not pass notes but rather kids pass notes through the cafeteria or on the activity field”. She indicated that they will leave the notes in a certain area and the other residents will pick up the note later.

Meeting with Resident F at the facility on June 27, 2018. Resident F was asked about her knowledge of the allegation of bullying on the dorm. She reports that residents tend to “antagonize” each other and staff will intervene. Resident F shared that “staff sometimes say something bad to certain kids but not to me, so I don’t pay attention”. She did indicate that “staff have favorites and they are not setting good examples for us. Sometimes they are disrespectful and swear, then we get into trouble if we swear.” Resident F was asked about staff’s use of phones on the dorm and she reported, “I was able to talk to Child 1 on the unit phone. She is one of my best friends. I only see staff using a phone when they are talking to Staff 14.” Resident F ended the interview with the following statement, “They want us to be these perfect little kids and they can’t even show us how”.

Meeting with Resident H at the facility on June 28, 2018. Resident H was asked about her awareness of the allegations of bullying and staff being inappropriate on the dorm. Resident H began the interview by stating, “staff are being lied on. Kids will lie because they think it will get them out of here. There is no reason to lie. I believe we have good staff that hold us accountable now.” Resident H did report that Staff 13 no longer works on the dorm which makes her happy. She states, “she was showing favoritism, was rude and mean. She really couldn’t work with the girls.” Resident H reports being told that residents will hide notes on the activity field but that she is not aware of staff passing notes. Resident H was asked about staff using phones and other devices on the dorm and she shared that, Staff 4 is on the phone and other staff use “Facebook”. She indicated watching a video of Staff 7 “twerking” on You Tube on a computer on the dorm. She also indicated that the residents found the video after looking up Staff 7’s name on You Tube. Resident H was unable to recall where the staff were during this time. Resident H ended the interview by stating “we get lied to by all the staff over simple stuff. They make promises that they don’t follow through with. Staff 14 told me that the boys were going to a men’s prison when I asked him where the boys were going.”

Meeting with Staff 1 at the facility on June 27, 2018. Staff 1 was asked about his knowledge of Resident A and Resident D cutting themselves. He indicated that he only heard from other staff about a student cutting himself with a razor in their room. He was unable to recall the resident name or a date he was informed of the incident. Staff 1 also reports being told that the resident was found with a razor in her room. Staff 1 was able to demonstrate on the dorm the location and process of residents obtaining razors for personal hygiene. Staff 1 was questioned about the allegations of residents having razors to cut themselves. He indicated that staff are to watch residents all the time especially during the process of them using razors for personal hygiene.

Meeting with Staff 2 at the facility on June 27, 2018. Staff 2 reports that she is the primary therapist for the girl's dorm at the facility. Staff 2 was asked about her knowledge of the allegations with Resident D and Resident A and provided the following information. "I was not here, and my supervisor called me and told me what had happened. He tried to talk to her, but she refused to talk with him, so he did a suicide assessment. When I came in on Sunday, she was in bed. I went to her room and saw that she had scraped her face and I asked her if she had anything else sharp in her room. She gave me a razor which is the type the girls shave with." Staff 2 was questioned how Resident D could still "scrape" her face without staff seeing and she replied, "Staff 6 was sitting outside of her room, but I don't believe she could have seen Resident D because of the position she was sitting in. She also had a hoodie pulled over her head. Physically staff could not see Resident D in her room." Staff 2 reports that Resident A told her about self-cutting but by that time, the cut was almost completely healed.

Staff 2 was asked about the allegations of bullying by staff and staff acting inappropriately at the facility and gave the following report, with frustration over the treatment of the girls on the unit. "Who really cares about the girls on this campus. I have talked to Staff 14 about Staff 9 being a friend and not a staff. There is a male staff passing notes or sharing information verbally between the residents and I believe Staff 9 has passed notes. Staff 9 will work on the boy's dorms and pass notes to the girls. Staff 9 will also build friendships with different girls which causes drama on the dorm." Staff 2 continued with her report of staff's behaviors on the dorm, "All of the staff are using their phones during working hours and I have seen Staff 9 using her iPad. The staff are on the phone Facebooking or watching YouTube too often and girls have told me that staff are showing them pictures on their phones." Staff 2 ended the interview by stating that she has shared this information only with Staff 14 because others have told her to take issues to the "Program Director".

Meeting with Staff 5 at the facility on June 28, 2018. Staff 5 was asked about the allegations of bullying and staff being inappropriate on the dorm. She reports that she does confront residents but doesn't "swear in front of kids". Staff 5 denied any bullying by staff but did report that she has shown residents a video of a fight. She also indicated that she has used facetime on the dorm but that it occurred "with coworkers for the girls". She continued, "my kids facetime me while I'm working but their grown kids". She was questioned about this and replied, "We cannot be on our phone if it's for personal business but if the kids are being spotted and accounted for we can step away and take a personal call or make a personal call". Staff 5 denied allowing residents to use a phone for Facebook but that she will allow them to use the phone to "call their families when the computers are not working". Staff 5 reports that she found out about Resident F being a friend of Child 1 and she denied that she allowed Resident F to speak to Child 1 on the phone. She reports that Child 1 is in foster care and a distant relative of hers. She indicated that Resident F's aunt is Staff 5's cousin's daughter and that she just found out about this connection. Staff 5 also reports that she let "some of the staff know" and that she "might have told my supervisor".

Meeting with Staff 6 at the facility on June 28, 2018. It should be noted that Staff 6 sat with her hoodie pulled over her head throughout this interview. Staff 6 was questioned about the allegations surrounding Resident D and she indicated having some awareness of the situation. Staff 6 provided the following information, "I was in the bay with another girl and then I went outside with some other girls. Staff 9 chased Resident D out of the building and when they came back Resident D had some bandages on. I sat in front of the door to her room after she went back into her room. I switched out with Staff 9 and when I came back Staff 9 was gone, and the chair was inside the room." Staff 6 then indicated that Staff 13 asked her to go somewhere but she was unable to recall where she went. She also indicated that upon her return to Resident D's room, Staff 9 had returned. Staff 6 reports that she was sitting in the doorway and Resident D was sitting on her bed when Staff 2 arrived, and she moved to a position that did not allow her to see Resident D while Staff 2 was in the room.

Staff 6 was asked about the allegations of bullying and staff being inappropriate on the dorm. Staff 6 gave the following report, "they are not bullying each other, they just engage in mean girl stuff. We confront them when they are mean. I have seen a staff yelling when the student would not listen." Staff 6 provided the following information regarding the allegations of staff using phones. "I have seen Staff 5 facetimeing with her family and other staff have used their phones. Staff 9 has used her iPad during working hours. Mostly they are using their phones to play music. The group leaders have a double standard and they use their phones a lot. This is just like the girls say, it's a double standard." Staff 6 also reports that they are required to tell the group leaders if a staff is using the phone for personal reasons.

Meeting with Staff 7 at the facility on June 28, 2018. Staff 7 was asked about the allegations of bullying and staff being inappropriate on the dorm. She denied any bullying was occurring on the dorm. However, she did report that "every staff gets on the phone all the time". Staff 7 shared a concern that occurred with her You Tube video. "I was not on shift and some staff allowed the kids to get on a computer. The kids told me they got on the computer and looked at my You Tube channel. They saw me dancing. I was wearing a yellow bikini. My You Tube channel is under my first name and you can find it with a google search. The kids would never tell me who let them find it and get on the computer." Staff 7 reports that this occurred about two months ago and that she learned about the incident when she returned to work. She also reports feeling "uncomfortable" about the residents seeing her in the video but "not offended". Staff 7 indicated telling her supervisor about the issue during a "casual conversation". Staff 7 ended the interview by stating that she knows staff cannot have students as friends on Facebook.

Meeting with Staff 13 at the facility on June 28, 2018. Staff 13 was asked about her acknowledge about the allegations of Resident D and she recalled the following. "Me and Staff 9 addressed her for being disrespectful and she yelled and stormed off to her room. Staff 9 asked her not to be disrespectful. When she went to her room, I followed her and asked her if she was ok. I told her to calm down and when she is ready, I will follow up with her. She got upset and wanted to go outside but I told her that she

couldn't because the staff outside already have four kids to watch." Staff 13 continued her recall of the incident, "she threw a water bottle and went back inside her room before Staff 9 went to her room and addressed her from the hallway. Staff 9 told her that she couldn't go outside because the staff already had four kids to watch." Staff 13 was asked about the allegation of yelling and she reports that Staff 9 never yelled at Resident D. Staff 13 then recalled, "Staff 9 came back to the room and Resident D ran out of her room and out of the door. Staff 9 ran out of the front door after her and caught up to her at the lower level. I was also there." Staff 13 continued, "Staff 6 came back into the dorm and had to watch all of the other kids. I believe that she had fourteen kids to watch by herself." Staff 13 was asked about the staffing ratio at that time and reported that she observed two other staff running to the dorm as she was running down the hill. She also suggested a belief that there may have been another staff on the dorm at that time. Staff 13 was asked about Resident D cutting her face and she reported, "we did a safety check and room search after she returned to her room and didn't find any blades. We must have missed the blade she had on her person. She did give us the pencil sharpener she reported to have gotten from her old roommate. We told staff that Resident D needs to be safety checked whenever she goes to the bathroom and Staff 6 was sitting outside of the door to her room. I don't know how Staff missed her cutting herself again and didn't see it."

Staff 13 was asked about the allegations of bullying and staff being inappropriate on the dorm. Staff 13 denied any bullying was taking place on the dorm. Staff 13 replied, "staff have been on the phone and when I see them I tell them to get off. The policy is that staff should not be on their phone when working." She was asked specifically about a personal call involving Staff 5 and indicated that "Staff 5 has not been on the phone in front of me". Staff 13 indicated not seeing Staff 9 on an iPad or phone and that she has explained to Staff 6 that she is not to be on the phone.

Meeting with Staff 9 at the facility on June 28, 2018. Staff 9 was asked about her awareness of the allegations with Resident D. Staff 9 gave the following report, "I was part of that. She was being aggressive, and we addressed her. She yelled and threw her water before going to her room. She refused to talk to us and wanted to go outside. When she couldn't go outside, she went back to her room and slammed the door real hard. She even refused to talk to me and I'm her primary staff." Staff 9 continued, "she came back out of her room and went out the back door. I was walking with her and talking when she started taking off her coat and yelling. She had a razor in her hand and said, 'you didn't care unless you see blood'. She started cutting herself while she ran. I was able to grab her arm and Staff 13 told me to restrain her. She tried to hit me, and we fell to the ground." Staff 9 reports that Staff 13 again told her to restrain Resident D and that once they had "gloves", they began to walk Resident D "back up the hill to the nurse". Staff 9 was asked what occurred after visiting the nurse and she gave the following information, "we went back to the dorm and I sat with her in her room. Staff 6 sat outside the door to the room. Staff 18 had asked that Resident D be brought down to his office to talk and when she came out of her room, she had marked her face. Later that day I found out that she was cutting her face." Staff 9 was asked how Resident D could have cut her face with staff present and she indicated that Staff 6 who was sitting

outside of her room was not watching her. She also indicated that Staff 6 could not see Resident D in her room from where she was sitting. Staff 9 was asked about the allegation of her swearing and slamming the door to Resident D's room and she denied swearing or slamming the door.

Staff 9 was asked about the allegations of bullying and staff being inappropriate on the dorm. Staff 9 reports when asked specifically about the bullying, "not really, if friends get mad they say little slick stuff to each other. Staff 9 was asked about the staff's phone use and other issues and gave the following information, "one of the girls told me about the You Tube incident and I heard that staff are passing information. Someone must have a hook up and doing stuff for them. If staff are doing things they are not doing it around me." About the phone use, "yea, staff use phones during work hours and all staff text". Staff 9 denied laughing at Resident A and that Resident A never showed her cut marks to Staff 9. She also denied every swearing or slamming Resident D's door.

Meeting with Resident I at the facility on July 17, 2018. Resident I was asked about the situation with Resident A and Resident D having razors in their rooms and cutting on themselves. Resident I reported, that she is on the highest status in the dorm which allows her to give direction and feedback to the other residents. Resident I gave the following report, "I remember Resident D having a razor, but I don't remember Resident A having one. I didn't see Resident D cutting herself, but I did see her come out of her room and staff wrapping her up. I think she was upset because she had a bad phone call from her mother, so she took it out on herself. I remember that she went outside and when she returned she cut herself."

Resident I was asked about the allegations of bullying on the dorm and she denied knowing of any bullying occurring. She did indicate that Resident A doesn't like the feedback that she gives her. She suggested that Resident A believes that "when other residents give her feedback they are bullying her". Resident I reported that she is on a higher level and can give direction to the lower residents. She indicated that she will remind residents that if they don't follow directions they can lose levels if they don't cooperate. Resident I reports, "I don't believe that I have bullied anyone, I might be aggressive, but I am only fulfilling my role. Sometimes there is not enough structure and they don't listen, so I have to yell." Resident I was asked specifically about the allegation that she laughed at Resident A after Resident A cut herself and she reports "I never talked to her about cutting herself because I never seen her cut".

On July 17, 2018 Resident D was interviewed again about her lack of a phone call to her grandmother the day she was in the hospital. She indicated that she was able to speak to her grandmother but not at the time she wanted. She was also asked about changes on the dorm since we last talked and she indicated that Staff 9 has "started bullying the kids" and that she is "toxic". Resident D described the label of toxic as Staff 9 "takes her anger out on us and when kids start being rude she becomes rude. I think she is trying to fit in and she won't hold people she likes accountable."

APPLICABLE RULE	
R 400.4112	Staff qualifications.
	<p>(1) A person with ongoing duties shall have both of the following:</p> <ul style="list-style-type: none"> (a) Ability to perform duties of the position assigned. (b) Experience to perform the duties of the position assigned.

<p>ANALYSIS:</p>	<p>Issues involving staff discovered during this investigation involve the following:</p> <p><u>Lack of appropriate supervision:</u> Staff 2 reported that staff 6 was sitting outside of Resident D room with the focus on providing supervision and she indicated a belief that Staff 6 was not able to observe Resident D. She also indicated that Staff 6 had a hoodie pulled over her head which would have further blocked her line of sight to Resident D. Staff 6 reported that she switched out with Staff 9 and when she came back no one was watching Resident D. Staff 13 reported not knowing how other staff missed Resident D cutting on herself again since she was supposed to be under close watch because of her actions earlier in the day. Staff 9 shared a belief that Staff 6, who was assigned to provide supervision for Resident D, was not watching her.</p> <p><u>Residents in possession of razors without staff knowledge:</u> Resident A had reporting that she was in possession of two razor blades and a pencil sharpener that she took from the kitchen area on the dorm. She also reports that the “large gray cabinet that these types of items are placed in was left unlocked. Resident A also reports that the staff did room searches but are not thorough enough to locate the items in her room. Staff 13 suggested that the staff did a room search and found no razor blades, which Resident D provided to staff later. Resident D shared that she obtained the razor blades from a past roommate. Staff acknowledged Resident D was able to obtain these items and keep them in her room undetected.</p> <p><u>Staff passing notes or information for residents:</u> Staff 2 shared knowledge that a male staff has passed notes or shared information between male and female residents and a belief that Staff 9 is also passing notes. She also shared the belief that Staff 9 will work on a male resident dorm and pass notes to the female dorms. Staff 9 denied passing notes or information but did suggest hearing that staff are passing information between male and female residents. She also reports that “someone must have a hook up and doing stuff for them”. Resident A shared that Staff 9 will pass notes for male and female residents. Resident E indicated that residents do pass notes but not through staff, rather passing notes by leaving the note in the cafeteria or on the activity field. Resident E’s report was that of Resident H.</p>
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	<p><u>Staff using their phone for personal time during the shift:</u> Resident D reported that staff are on “their phones all day”. Resident H indicated that Staff 4 uses her phone during working hours. Staff 2 indicated that “all staff are using their phones during working hours and that she has observed one staff using their iPad. Staff 6 reported that she has seen staff using their phones during working hours. Staff 7 shared that “every staff gets on the phone all the time”. Staff 13 reports observing staff using their phones during working hours and telling them to get off. She also reports that the facility’s policy is that staff should not be using their phones during working hours. Staff 9 reported that “staff use phones during work hours and all staff text”.</p> <p><u>Staff using social media during shifts or allowing residents to use social media:</u> Resident D reports that Staff 5 has shown the residents a fight that she filmed. She also reports that Staff 5 has engaged in a video chat, allowing some of the residents to speak to a youth outside of the program. Resident D indicated that Staff 9 has allowed a resident to use Facebook on her phone. Resident F reports that a staff allowed her to talk to a youth outside of the program on the unit phone. Resident H reports that the residents were able to view Staff 7 “twerking” on You Tube when the residents accessed the dorm computer. Staff 2 reports knowing that staff will use Facebook or watch You Tube and that the residents have told her that staff show them pictures from their phones. Staff 5 admitted that she has shown residents a video of a fight she filmed and that she has also used facetime on the dorm. Staff 6 confirmed this report by stating that she has observed Staff 5 using facetime with her family while working. Staff 6 also reports observing Staff 9 using her iPad during working hours. Staff 7 indicated being aware that some staff allow the residents to use the computer for social media on the dorm.</p> <p><u>Boundaries issues between staff and residents:</u> Resident B reports observing Staff 9 favoring “Resident I over the rest of the residents”. Resident F reports that “staff have favorites”. Resident H stated, Staff 13 shows favoritism with different residents. Staff 2 reports that Staff 9 will build friendships with different girls which causes drama on the dorm”. Staff 2 reports speaking to Staff 13 and Staff 9 about being a staff rather than a friend to the residents. Resident D shared a belief that Staff 9 is trying to fit into the residents and “will not hold people she likes accountable”.</p>
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	Overall, reports from both staff and residents support the lack of appropriate staff supervision and interactions with residents. Reports support that staff are not following the policies and procedure for appropriate interactions with residents as outlined in the facilities guidelines for staff. As such, staff are demonstrating an inability to perform the functions of their job as they all know the requirements and yet do not follow them.
CONCLUSION:	VIOLATION ESTABLISHED

APPLICABLE RULE	
R 400.4157	Behavior management.
	(2) At a minimum, the behavior management system shall include all of the following: (b) Positive intervention strategies to assist residents in developing improved problem solving, self-management, and social skills.

ANALYSIS:	<p><u>Bullying and inappropriate staff behaviors on the dorm:</u> Resident A reported that they now have “residents threatening to fight or run away often”. She also reports that staff have been “grumpy” and “not paying attention to the concerns of the residents”. She indicated “no longer feeling safe at the facility”. Resident A reports being called names and along with being told to “go fuck” yourself by Staff 9. Resident B denied that bullying was occurring on the dorm, but she did report that she has seen staff get upset with residents. Resident C also denied bullying was occurring and believed it to be that residents were “mean to each other”. She did report that sometimes staff get “grumpy” with residents. Resident D reports that Staff 9 “will not speak to her when she has a rating of negative and will curse at residents”. Resident D also reports that “all staff curse at residents”. Resident F indicated that staff are not setting good examples for residents and that at times “they will swear or be disrespectful”. Staff 6 reported that residents are not bullying each other but engaging in “mean girl stuff”. She did report observing a “staff yelling at a resident who would not listen”. Staff 9 who denied slamming the door to Resident D’s room or swearing, reported that there is no bullying going on. She indicated that if residents get mad “they say little slick stuff to each other”. Resident I reported not believing that she has bullied any of the other residents. She described herself as becoming “aggressive” but that she is “only fulfilling” her role as a high-level resident. She reports that there is not enough structure and when the other residents don’t listen she has to “yell”. She also reports a belief that when she gives feedback the other residents believe she is bullying them. Resident D reports that Staff 9 has become “toxic and is bullying the kids on the dorm”. She also reports that Staff 9 will “take out her anger on the residents” and “becomes rude towards the residents”.</p> <p>Overall, given the different reports and the similarities of reports from residents and staff members, there appears to be a culture which is not treatment based on this dorm. It appears that staff are not following the guidelines presented by the administration of this facility and have developed methods of interacting with the residents that are not supporting a trauma-based focus. It is understood that the resident’s reports will be greatly affected by their own traumatic past; however, many of their reports are supported by different staff member’s reports.</p>
CONCLUSION:	VIOLATION ESTABLISHED

ADDITIONAL FINDINGS:

During this investigation, it was noted that several sources interviewed indicated that the facility is not providing the appropriate staff-to-student ratio on the dorm being investigated.

INVESTIGATION:

Meeting with Staff 10 and Staff 11 at the facility on June 26, 2018 to initiate the investigation. Staff 10 was asked about the allegations of the dorm not always being in ratio with staff to residents. He indicated that at times a staff will not show up on time for the first shift and they will have residents stay in their beds until the correct staffing ratio is obtain. He also indicated that at times, they are short staffed because the facility currently is significantly short of staff. Staff 10 also reports that residents are not always aware of the location of staff, therefore; not aware that the full complement of staff is present.

Meeting with Staff 1 at the facility on June 27, 2018. Staff 1 reported that yesterday, there were “only two staff present on the dorm from 3:00 pm to 4:40 pm” with fifteen residents. He also reported that “the therapist and intern were running a group on the dorm from 3:20 pm. to 4:00 pm”. Staff 1 indicated that at 4:10 pm yesterday, “there were only two male staff present” for fifteen female residents. Staff 1 also indicated speaking to a Campus Coordinator and being told that one of the female staff no longer works on the dorm. He reports that this is “not the first time being stuck with only two staff” and a full unit, so when this happens they “keep all of the residents together in one bay”. Staff 1 shared that he has felt “uncomfortable” two to three times with the staffing situation since returning to work.

Meeting with Staff 2 at the facility on June 27, 2018. Staff 2 reported that “the dorm is not always fully staffed” and in “the last few months it’s gotten worst”. “The girls have a lot of issues and there has been a lot of staff turnover”. Staff 2 was asked what action she has taken, and she reports speaking to Staff 14 about her concerns.

Meeting with Staff 5 at the facility on June 28, 2018. Staff 5 was asked about her knowledge of any staffing concerns at the dorm and she provided the following information. “Yesterday, we were out of ratio for the first two hours of the day.”

Meeting with Staff 6 at the facility on June 28, 2018. Staff 6 was asked about allegations that the dorm does not always have the correct ratio of staff to students. She reports no concerns and that they had four staff on the dorm yesterday.

Meeting with Staff 9 at the facility on June 28, 2018. Staff 9 was asked about any concerns with the staffing on the dorm and she gave the following report. “When I asked about having four staff every morning, they told me that they cut it down to three during

school days. On the weekends, there is supposed to be four on but there are not four staff always available. Most of the time we don't have four, so we got used to running the dorm with two staff." Staff 9 was asked what action she takes when they are short staffed, and she reports that they contact the Campus Coordinator and let them know. She also shared that the facility is eighteen fulltime employees short for the whole campus.

Meeting with Resident A at the facility on June 27, 2018. Resident A was asked about the staff supervision on the dorm and gave the following report. "Yesterday we had only two staff for half the day and we are supposed to have four staff on. They don't do anything about us only having two staff."

Meeting with Resident B at the facility on June 27, 2018. Resident B was asked about staffing at the dorm and gave the following information. "Often it happens that we don't have enough staff. Yesterday, we only had two staff working most of the shift. Staff are quitting from working our dorm." Resident B also shared being told that a "Group Leader can have a staff-to-student ratio of 1:6". She ended the interview by stating that "the biggest issue we have is consistency because of the limited staff".

Meeting with Resident C at the facility on June 27, 2018. Resident C was asked about the level of staffing on the dorm. Resident C reports, "there are hardly ever four staff on the dorm. One day we only had one staff early in the morning and they didn't wake us up because it was not a school day. I think most of the time we have two and sometimes three staff working on the dorm." Resident C also stated, "last night Resident D walked off the dorm and we only had one staff, but we didn't think we had any staff on the dorm". Resident C ended the interview by stating a belief that residents "who say they don't are only trying to get the program into trouble. I know that Staff 10 and 11 understand the concerns, but they told me they fully staff the program".

Meeting with Resident D at the facility on June 27, 2018. Resident D was asked about her view of the staffing on the dorm. She reports that "sometimes we only have two staff with us and I remember a time a couple of weeks ago when there were no staff on the dorm. They called for more staff and no one came.

Meeting with Resident E at the facility on June 27, 2018. Resident E was asked about her understanding of staffing concerns on the dorm. She gave the following information, "we have short staff and are supposed to have four or five and we generally have two or three.

Meeting with Resident F at the facility on June 28, 2018. Resident F was asked about any concerns about staff on the dorm and she gave the following report. "Sometimes we can be without staff because they have a trust level and leave us alone. There is supposed to be four staff at a time and at times there are only two or three. It happens a lot. It's like they don't come into work."

Meeting with Resident H at the facility on June 28, 2018. Resident H was asked about alleged issues with the staffing on the dorm. She gave the following information, "Saturday morning we woke up to only one male staff on the dorm. We are short staffed almost every shift with only one or two staff." Resident H was asked about any further concerns on the dorm and she stated, "we have issues because things are inconsistent because we have limited staff, when it should be eleven we only have five. When you leave it will go back to the way it was, being inconsistent."

Meeting with Resident I at the facility on July 17, 2018. Resident I was asked about any staffing issues she was aware of on the dorm and she provided the following. "We only had two staff on the dorm during the time Resident D was struggling and we are short staffed every day".

APPLICABLE RULE	
RFCAN 15-39007	Mental Health Behavior Stabilization Staffing Ratio
	Awake Hours: 1:4 Nighttime Hours: 1:10
ANALYSIS:	Five of six staff interviewed and asked about the staffing ratio on the dorm, reported that the dorm is not always within the staffing ratio. Seven of seven residents interviewed and asked about staffing ratios on the dorm report that the dorm is not always staffed appropriately. Although, there are some specific times and days identified that the dorm is under staffed, the general presentation is that this occurred more often. The facility indicated that they are generally under staffed by approximately seventeen full time staff. The facility also reports that they are providing other staff the opportunity for overtime to help elevate the issues with staffing.
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

With an acceptable corrective action plan, it is recommended that no change be made to the license of this child caring institution



Paul Fatato
Licensing Consultant

8/2/2018
Date

Approved By:



August 24, 2018

Claudia Triestram
Area Manager

Date